COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

DATE:

PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:
AKA'S:		

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.		
LAST NAME OR ENTITY: **COUNTY OF SAN DIEGO TBS Children's Mental Health Services**	FIRST NAME:	MIDDLE INITIAL:
ADDRESS: 3255 CAMINO DEL RIO S.	CITY/STATE: SAN DIEOG, CA	ZIP CODE: 92108
TELEPHONE NUMBER : (619) 563-2756 FAX: (858) 467-9029	DATE:	

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.		
LAST NAME OR ENTITY: **COUNTY OF SAN DIEGO,** ***CONTRACTED PROVIDERS, OR OTHERS - SEE PAGE 3 FOR LIST OF SERVICES / PROGRAMS***	FIRST NAME: N/A	MIDDLE INITIAL:
ADDRESS: N/A	CITY/STATE: N/A	ZIP CODE: N/A
TELEPHONE NUMBER: N/A	DATE:	
TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory Results
- ☐ Dental Records
- ☒ Psychiatric Records
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy Records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing Records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐	
SIGNATURE OF STAFF PERSON:	DATE:
SIGNATURE OF MEDICAL DIRECTOR:	DATE:

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THERAPEUTIC BEHAVIORAL SERVICES

By signing below, you are authorizing HHSA-TBS and its contract providers (New Alternatives, Inc., and Mental Health Systems, Inc.) to obtain and exchange information with all agencies so indicated on this page.

___ **ALL PROVIDERS LISTED**

___ Aurora Behavioral Health
___ Casa De Amparo
___ Community Research Foundation
___ Episcopal Community Services
___ Family Health Center of SD
___ Fred Finch Youth Center
___ HHSA – AMHS
___ HHSA - CMHS
__X__ Medi-Cal
__X__ Mental Health Systems, Inc.
__X__ New Alternatives, Inc.
___ North County Lifeline, Inc.
___ Palomar Family Counseling
___ Providence Community Services
___ Public Conservator Office
___ Rady Children's Hospital / Outpt Psych.
___ San Diego Center for Children
___ SAY
___ SDYCS
___ Sharp Mesa Vista
___ St. Vincent de Paul
___ Telecare Corporation
___ UCSD-CAPS
___ UPAC
___ Vista Hill Foundation
___ Walden Family Services
___ YMCA
___ Youth Enhancement Services

Current Program or Therapist (write name):

___ Other:_____
___ Other:_____
___ Other:_____
___ Other:_____

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	